PLANNING COMMITTEE MEETING #2
"BUILDING BRIDGES FOR SAN DIEGO LTCIP DELIVERY SYSTEMS"
SUMMARY NOTES
JULY 14, 2004 · 12:00-2:00 P.M.

I. Welcome and Introductions

Thirty-four stakeholders in attendance. Guest presenters: Sharon Larson, Provider Relations & Contracting Manager, Elder Care of Wisconsin, Inc., and Steve Landkamer, Program Manager, Wisconsin Department of Health and Family Services

Purpose of meeting: Follow-up to 10:30 Planning Committee meeting to discuss strategies and successful techniques for improving chronic care management for the elderly and disabled in fee-for-service or integrated systems with staff from the Wisconsin Partnership Program. The Partnership Program is a unique variation of PACE (Program of All-Inclusive Care for the Elderly), which does not depend on the adult day care center and allows enrollees to keep their own primary care physician.

II. Overview of Elder Care and Wisconsin Partnership Program (WPP)

- Elder Care of Wisconsin, Inc is one of four non-profit, community-based organizations that contracts with the State to provide Partnership services to approximately 450 enrollees who are nursing home certifiable, Medicaid or Medicaid/Medicare beneficiaries.
- Care Management team comprised of participant, primary care physician (PCP), nurse practitioner (NP), registered nurse (RN), social worker and service coordinator
- Physician brought to program by a potential participant or contacts program directly to become involved; if interested, team NP meets with PCP to establish collaborative relationship
- Elder Care has an agreement with each large physician group; all primary and specialty physicians covered under one agreement
- Program is most effective if PCP is invested in the model and is willing to collaborate
- Physician support from care team -NP acts as liaison between PCP, participant and remainder of team; provides initial history and physical, periodic re-evaluation, and assistance with medication management; attends participant's doctor visits to update PCP on medication needs, health changes, and adjustments to the care plan
- Role of RN-provides both skilled nursing care and care management (e.g., assistance with medication compliance, in-home functional and health assessments, health education); oversees provision of personal care services
- Role of social worker- keeps up-to-date about the various community resources available; helps to coordinate use of community services; provides supportive counseling to the participant, family members and caregivers
- Role of Service Coordinator - ensures timely communication among participants, Care Team members, other Elder Care staff, physicians' offices, and community service providers; schedules medical/health appointments, arranges transportation, and coordinates participant's services
- Nurse on-call 24/7; care team is first point of contact with participant
- High PCP satisfaction - 88% of PCPs believe that membership in the Partnership Program makes it easier to manage their patient's care; Over 70% of PCPs almost always or usually have needed patient background information (medical history, special needs, etc) to provide appropriate services

III. Highlights from Group Discussion:

- Partnership organizations subcontract with community-based organizations on an individual basis or through informal networks to provide needed social and supportive services

- Consumer/caregiver is active part of care team; program encourages consumer direction, especially in choosing caregiver
- Partnership programs use a web-based application for functional eligibility
- There are approximately 110 physicians currently participating in Elder Care; many hear about program through word of mouth and/or medical residency clinics
- Benefits for participating physicians: less administrative work, enhanced care management support
- Medicare and Medicaid capitation payments are made to the Partnership organizations
- Organizations subcontract with various providers, including physicians, and pay them on a Fee-for-Service (FFS) basis out of the cap rate
- FFS rates are developed locally in Wisconsin, which allows for greater flexibility in reimbursing providers compared to traditional FFS rates
- PCP usually sees patient in office, except in rural areas. Physicians receive higher reimbursement rate for home visits
- Concern re: house call practice -what may make economic sense to the system, may not make economic sense to the physician and/or team of providers delivering care in the home
- House call practice can be financially feasible with proper planning, organizational structure and staffing. Technical assistance, training and other valuable information and resources for physicians and related professionals and agencies interested in improving care of patients in the home is available from the American Academy of Home Care Physicians (http://www.aahcp.org/)
- There is currently no volunteer component in the Elder Care program, but staff are exploring ways to incorporate
- The four Partnership Programs serve six counties with a total enrollment of approximately 1700 (~450 in Elder Care)
- Percent eligible versus percent enrolled in WPP unknown at this time
- Care team members are employees of Elder Care
- Elder Care currently has 11 care teams that meet once/week; physician attends, if needed (usually by phone)
- Elder Care began providing dental services through a dental residency program located in Milwaukee and has since hired its own dentist (a former resident) to provide complete dental services, in-house.
- Future growth opportunities- rural areas and Hispanic and African American communities.

IV. More information

- Wisconsin Partnership Program: www.elderc.org or http://dhfs.wisconsin.gov/WIpartnership/
- PowerPoint slides from this meeting are available on the LTCIP website at http://www.sdcounty.ca.gov/cnty/cntydepts/health/ais/ltc/ or by calling (858) 495-5428